2003

EMPLOYEE ENROLLMENT GUIDE

Understanding Your Medical & Dental Coverage

EFFECTIVE JANUARY 1, 2003

HCA 50-100 (11/02)

Washington State Health Care Authority
Public Employees Benefits Board

Forms Enclosed Inside!

Contact the Plans

For questions about a specific medical or dental plan, contact the Public Employees Benefits Board (PEBB) plans listed below.

Medical Plans	Web site address	Customer service phone numbers
Group Health Cooperative of Puget Sound	www.ghc.org	206-901-4636 or 1-888-901-4636 TTY/TDD 711 or 1-800-833-6388
Group Health Options, Inc.	www.ghc.org	206-901-4636 or 1-888-901-4636 TTY/TDD 711 or 1-800-833-6388
Kaiser Foundation Health Plan of the Northwest	www.kp.org/nw	1-800-813-2000 or Portland 503-813-2000 TTY/TDD 1-800-833-6388 (WA) TTY/TDD 1-800-735-2900 (OR)
PacifiCare of Washington, Inc.	www.pacificare.com	1-800-932-3004 TTY/TDD 1-800-786-7387
Premera Blue Cross	www.premera.com	1-800-722-1471 TTY/TDD 1-800-842-5357
RegenceCare	www.wa.regence.com/pebb	1-800-376-7926 TTY/TDD 206-389-6728 or 1-877-727-4357
Uniform Medical Plan	www.ump.hca.wa.gov	425-670-3000 or 1-800-762-6004 TTY/TDD 1-888-923-5622

Dental Plans	Web site address	Customer service phone numbers
DeltaCare, administered by Washington Dental Service	www.deltadentalwa.com	1-800-650-1583
Regence BlueShield Columbia Dental Plan	www.wa.regence.com/pebb	1-800-376-7926
Uniform Dental Plan	www.deltadentalwa.com	1-800-537-3406

If you want additional information about PEBB coverage, call a benefits specialist toll-free at 1-800-700-1555, Monday through Friday, 8 a.m. to 5 p.m., or visit our Web site at www.pebb.hca.wa.gov.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805.
TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Contents

The health plan comparisons in this guide are based on information believed accurate and current, but be sure to confirm data before making decisions.

What You Need To Know

Welcome

The Washington State Health Care Authority (HCA) is the agency that purchases and coordinates health insurance benefits for state employees through the Public Employees Benefits Board (PEBB) program. This guide provides you with some basic information about your medical and dental coverage and will help you choose a health plan.

The benefits described in this guide are brief summaries. For a complete description of your benefits, refer to the plan's certificate of coverage. (See the "Glossary" for definition.) You will receive your certificate of coverage directly from your plan after you enroll.

Some benefits described in this booklet are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

How to Enroll

You must enroll yourself and your eligible dependents in a PEBB medical or medical and dental plan **within 31 days** of the date you first become eligible to apply under PEBB rules. Complete the enrollment form(s) in the back of this guide and return it to your payroll, personnel, or benefits office within 31 days. If you do not submit an enrollment form within that period, you will automatically be enrolled in the Uniform Medical and Dental Plans as a single subscriber. Claims for benefits under those plans will be denied until you submit a completed enrollment form. Your next opportunity to change plans or add dependents will be the next open enrollment period. For exceptions, refer to pages 5 and 6.

If both you and your spouse/ qualified same-sex domestic partner are eligible employees, you may either enroll yourselves separately (and choose different medical and dental plans), or one of you may cover your spouse and all eligible family members (under the same medical and dental plans). If you have children, they may be covered under only one PEBB subscriber's account. Verification of your family members' eligibility for PEBB coverage may be requested at any time by the HCA or the PEBB plans.

When you fill out your enrollment form, you will be asked to select a medical and a dental plan. Follow these steps to join a plan:

1. Read this guide.
2. Check to see which medical plans are offered in your area. See the "Plans Available by County" section in this guide.
3. Gather information.
   a) Read about the medical and dental plans that interest you. See the "Medical Benefits Comparison" and "Dental Benefits Comparison" charts. The health plans also have Web sites; their addresses are listed on the inside front cover of this guide.
   b) Find out about the medical plans' monthly premiums (there is no employee contribution for dental coverage). Medical plan rates are shown in the "2003 Monthly Employee Premiums" section or can be obtained from your personnel, payroll, or benefits office.
   c) Call the plans to request a list of their providers or ask questions. You can also find out if your provider participates with the medical plan you choose by checking the provider directory on the PEBB Web site at www.pebb.hca.wa.gov or by calling the plan directly. If you are choosing a doctor or other provider for the first time, be sure to find out if he or she is accepting new patients.
4. Choose your medical/dental plan. There are no restrictions or waiting periods for pre-existing conditions under any of the PEBB medical or dental plans.
5. Complete the enrollment form (if you're adding a spouse/ qualified same-sex domestic partner to your coverage, you'll need to complete the additional form[s] in the back of this guide) and return it to your payroll office or the person in your agency who handles benefit changes within 31 days of the date you become eligible to apply. Call your personnel, payroll, or benefits office or the HCA at 360-412-4200 or 1-800-700-1555 if you need help completing the enrollment form.

It is your responsibility to know your benefits. To avoid penalty or loss of benefits, please note all requirements for using providers, preauthorization, and medical review as specified in each plan's certificate of coverage.

Eligibility

Employees

The following employees of state government, higher education, K-12 school districts, educational service districts, employer groups, and employee organizations representing state civil service workers are eligible to apply for PEBB coverage in accordance with Washington Administrative Code (WAC) 182-12-115 (for information on when coverage begins, see "Effective Dates of Coverage" on page 4):

Permanent Employees

If you work at least half-time per month and are expected to be employed for more than six months, you are eligible to apply for coverage on the first day of your employment.

Nonpermanent Employees

You are a nonpermanent employee if you work at least half-time and are expected to be employed for no more than six months. If your employment continues beyond the initial six-month period, you may apply for coverage on the first day of the seventh calendar month of employment.

Seasonal Employees

If you work at least half-time per month during a designated season for a minimum of three months but fewer than nine months per year, and you have an understanding of continued employment with state government season after season, you may apply for coverage on the first day of employment. You are not eligible for the employer contribution during the break between seasons of employment, but may be eligible to continue coverage by self-paying premiums.

Career Seasonal/ Instructional Employees

If you work half-time or more on an instructional year (school year) or equivalent nine-month seasonal basis, you may apply for coverage on the first day of employment. You are eligible for the employer contribution for health care coverage during the off-season following each period of seasonal employment.

Part-Time Faculty

If you are employed on a quarter/semester to quarter/semester basis of half-time or more employment at one or more state institutions of higher education, you may apply for coverage at the beginning of the second consecutive quarter/semester of employment. For purposes of determining eligibility, spring and fall are considered consecutive quarters/semesters.

Appointed and Elected Officials

If you are a legislator, you may apply for coverage on the date your term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible to apply for coverage on the date their term begins or when they take the oath of office, whichever occurs first.

Judges

If you are a justice of the Supreme Court, or a judge of the Court of Appeals or the Superior Courts, you are eligible to apply for coverage on the date you take the oath of office.

Medicare Eligibility

For employees and their spouses/qualified same-sex domestic partners age 65 and older, PEBB-sponsored medical plans will provide primary coverage, and Medicare coverage will be secondary. However, active employees 65 and older may choose to reject PEBB-sponsored medical coverage and choose Medicare as their primary insurer. If you do so, you will receive no PEBB coverage. The HCA can provide you with more information.

In most situations, employees and their spouses/qualified same-sex domestic partners can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates or retires. Upon retirement, Medicare will become the primary insurer, and the PEBB-sponsored medical plan becomes secondary.

School District and Employer Group Employees

If you are a Washington State school district or employer group employee, you may apply for PEBB coverage if the PEBB plans are the only medical plans offered through your employment and:

- The eligible members of a bargaining unit enroll as a unit, and the unit is approved for participation by the HCA, or
- All non-represented eligible employees enroll as a group, and the group is approved for participation by the HCA.

Employee eligibility is determined by the bargaining unit contract or terms of employment. For more information about employee eligibility, see your plan's certificate of coverage.

Dependents

If you are enrolled in a medical and/or dental plan, you may also enroll the following dependents in the same plan(s):

- Your lawful spouse or qualified same-sex domestic partner.
- Your dependent children through age 19. The term "children" includes your natural children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the qualified same-sex domestic partner, or children specified in a court order or divorce decree.

Married children who qualify as your dependents under the Internal Revenue Code and additional legal dependents approved by the HCA are included.

Dependent children who are full-time students or who are developmentally or physically disabled are eligible beyond age 19 under the following conditions:

- Students age 20 through age 23 are eligible if they are: (i) dependent on you for maintenance and support, and (ii) are registered and attend full-time an accredited secondary school, college, university, vocational school, or school of nursing. Coverage of dependent students continues year-round for those who attend three of the four school quarters and for three full calendar months following graduation as long as you are covered at the same time. To make sure that your dependent meets the eligibility criteria above, you'll be required to provide proof of student status annually.
- Dependent children of any age are eligible if they are incapable of self-support due to developmental or physical disability, provided that their condition occurred before age 20 or during the time they were covered under a PEBB plan as a full-time student. Proof of such disability and dependency must be provided to the HCA upon application and as periodically requested thereafter.
- Your dependents who were previously covered under a K-12 health plan and who are not otherwise eligible for PEBB coverage may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation of coverage, the PEBB plan must be immediately replacing a K-12 health plan with no lapse in coverage.
- If your dependent loses eligibility under a PEBB plan for active employees due to your death, your dependent(s) may continue coverage under a retiree plan provided he or she will immediately begin receiving a monthly benefit from a state of Washington-sponsored retirement system as listed in the answer to question three in the "Questions and Answers" section on page 7.

If your child is enrolled in a college out of your plan's service area, he or she may receive network-level benefits through any licensed provider. However, benefits are administered differently from plan to plan. Contact your plan for details.

Enrollment

Effective Dates of Coverage

New employees

If you're eligible, your coverage begins on the first of the month following the date of employment. If your employment begins the first working day of the month, coverage begins on that day. This applies to permanent, seasonal, and career seasonal/instructional employees. Coverage will extend through the last day of the month in which your employment ends. There are exceptions for certain employee groups (see "Eligibility" section on page 2 for definitions).

Nonpermanent employees

Coverage begins on the first day of the month following six consecutive months of employment at a level of half-time or more.

Part-time faculty

Coverage begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.

Appointed and elected officials

Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of a month, coverage begins on the first day of their term.

Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of government, and judges, on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins or the oath of office is taken.

School district employees

The effective date is determined by the terms of employment or collective bargaining agreement. Participation of the bargaining unit or nonrepresented employees is subject to approval by the HCA.

Employees returning from leave

If medical premiums were self-paid for the employee, employer contributions for PEBB coverage will begin the first of the month in which the employee returns to work. If an employee has self-paid premiums for any month in which he or she is eligible for premium contribution by his or her employer, the employee will be reimbursed any self-paid premium payment.

If a break in coverage occurred because medical premiums were not self-paid, coverage will begin the first of the month following return to work.

New dependents

Coverage for newborns and newly adopted children begins on the date of birth or the date you assume legal obligation for support in anticipation of adoption. Coverage for other new dependents (e.g., spouse/qualified same-sex domestic partner or stepchild) begins on the first of the month following his or her eligibility date. (Please refer to "Adding and Dropping Dependents" to find out how and when to enroll your family members in PEBB coverage.) If your child is born or adopted before the 16th of the month, you will be charged the full month's premium. You will not be charged until the following month for children born or adopted on or after the 16th of the month.

If a newly eligible subscriber or dependent other than a newborn child is confined in a hospital, skilled nursing facility, approved chemical dependency treatment facility, or other inpatient facility when coverage would normally begin, no benefits will be provided for services rendered before discharge.

Identification Cards

After you enroll, you'll receive an identification card from your plan. Show this card to your providers when you receive care. If you have any questions about your identification card, contact your plan directly. (The Uniform Dental Plan does not issue identification cards.)

Adding and Dropping Dependents

You may add eligible dependents midyear if you have a qualifying change in family status. See "Eligibility" on page 2 for a list of eligible family members, and refer to your plan's certificate of coverage for time limitations. Changes in family status include:

- Marriage or establishment of a qualified same-sex domestic partnership.
- Birth, adoption, or placement of a child for adoption.
- The loss of other continuous, comprehensive medical coverage for dependents who have previously waived coverage.

Dependents must be enrolled within 31 days of eligibility, except in the following situation:

- Newborns or newly adopted children must be enrolled within 60 days of eligibility if addition of the new dependent increases your monthly premium.

When a new dependent becomes enrolled before the 16th day of the month, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

- Dependents who lose other medical coverage must enroll in a PEBB plan within 31 days of the date their other coverage ends. Dependents will be required to provide proof of continuous, comprehensive health-care coverage up to the time their other coverage terminates. If the dependent meets enrollment criteria, PEBB-sponsored coverage will begin the first day of the month after the other coverage is terminated.

If you want to add dependents, return a completed enrollment form (in the back of this guide) to your payroll, personnel, or benefits office or the person in your agency who handles benefit changes within the time limits previously described. Otherwise, you must wait until the next annual open enrollment period to make the change.

You may also cancel an enrolled family member's coverage midyear when you have a change in family status. You must notify your payroll, personnel, or benefits office and cancel your dependent coverage in the following situations:

- Upon your divorce
- When your qualified same-sex domestic partnership ends
- Upon your dependent's death
- When your dependent child reaches the age limits for participation; see "Dependents" on page 3
- When your spouse, qualified same-sex domestic partner, or child no longer meets the definition of an eligible dependent

Important!
Employees who have waived medical coverage for themselves or family members may have an additional opportunity to enroll in medical coverage. If you have a qualifying change in family status—marriage, establishment of a qualified same-sex domestic partnership, birth, adoption, or placement for adoption—you may enroll members that previously waived coverage, provided that enrollment is requested within 31 days of marriage or establishment of a qualified same-sex domestic partnership or within 60 days of birth, adoption, or placement for adoption. For example, if you have a birth, you may also enroll your spouse who previously waived medical coverage as long as you request the enrollment within 60 days from the child's birth date. However, you may not change medical or dental plans.

Waiving Medical Coverage

You may waive medical coverage or your eligible dependent(s) may waive PEBB medical and or dental coverage. If you waive medical coverage, you will still continue dental, life, and long-term disability coverage. You cannot waive coverage for yourself and continue to provide coverage to your dependents.

To waive medical coverage, you must indicate it for each family member in Sections 1, 2, and 3 of the enrollment form, and certify you have other health care coverage.

If you have other coverage, you may want to look up the coordination of benefits rules for your other coverage and compare the advantages and disadvantages of participating in one or both plans.

Once you or your dependent waives coverage, you may enroll in PEBB coverage midyear if you show proof that you had other continuous, comprehensive coverage and you (or your dependent) do so within 31 days of the date you lose your other

coverage. You may re-enroll during the annual open enrollment period without proof of continuous, comprehensive coverage. However, K-12 employees may not be permitted by their school district to re-enroll until the next open enrollment or renegotiation period.

You and your dependents may have an additional opportunity to enroll if you have a new dependent as a result of marriage, establishment of a qualified same-sex domestic partnership, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or establishment of a qualified same-sex domestic partnership, or within 60 days of birth, adoption, or placement for adoption.

If your doctor, dentist, or health care facility discontinues participation in your plan, you may not change plans until the next open enrollment period. Also, if you transfer from one agency or school to another during the plan year, you are not permitted to change plans, except as explained in "Changing Your Plans."

Changing Your Plans

Open enrollment is the period set aside each year for you to change health plans, add dependents, or enroll in a medical plan if you have previously waived coverage. In most cases, you are not allowed to change plans except during open enrollment. Your coverage remains in effect for an entire year (January 1 through December 31) unless your employment with the state ends or you waive your medical coverage. However, you may be able to change plans during the plan year in the following situations:

- If you move, you may change your plan within 31 days of the move date under the following conditions:
  - If you move from your plan's service area, you must enroll in a plan available in your new locality, or
  - If a plan has not been previously available to you in your former locality and you move into that plan's service area, you may enroll in that plan.

All such plan enrollment changes take effect on the first day of the month following the date you move. **Please contact your payroll, personnel, or benefits office if you have an address change.**

- If a court order requires you to provide medical coverage for an eligible spouse/qualified same-sex domestic partner or child, you may change medical plans and add the dependent. The change is effective the first day of the month following the enrollee's notification or the date of the application.
- If you retire, you may change plans at the time you apply for retiree coverage. The change is effective the first day of the month following the date your active employment ends.
- Seasonal employees whose off-season occurs during open enrollment may change plans within 31 days of returning to work.

To initiate a plan change under any of the above listed circumstances, contact the payroll, personnel, or benefits office where you work.

Questions and Answers

Covering Dependents

1 Is my dependent eligible?

If you are enrolling yourself, you may also enroll your legal spouse or qualified same-sex domestic partner and eligible children. See the "Dependents" section on page 3 for the definition of eligible children.

2 If one of my children attends college full-time, can I still enroll in a managed care plan not offered in the county in which he or she goes to college?

Yes, although most managed care plans require that you permanently reside within the plan's service area in order to enroll. If one or more dependents live outside your plan's service area temporarily while attending an accredited secondary school, college, university, vocational school, or school of nursing full-time, they may receive benefits through any licensed provider. Claims for those providers will be paid as if the service had been received through plan-designated providers. The dependents will be responsible for the same copayments that apply to in-area enrollees. For purposes of preauthorization, the plan will assume the role of the primary care provider. The plan must authorize all services in advance (including routine care), except when emergency or urgent care is needed.

3 If I die, can my surviving dependents continue PEBB coverage?

If you die, medical and dental coverage may continue for your covered dependent(s) for up to 36 months under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Contact the HCA for details.

Your dependent's coverage may continue if you die and your covered dependent(s) immediately receives a monthly benefit from one of the following retirement systems sponsored by the state of Washington:

- Public Employees Retirement System (PERS) 1, 2, or 3
- Teachers' Retirement System (TRS) 1, 2, or 3
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF) 1 or 2
- State Judges/Judicial Retirement System
- Washington State Patrol Retirement System (WSPRS) Plan 1 or 2
- Higher Education Retirement Plans
- Washington School Employees Retirement System (SERS) 2 or 3

In this situation, your spouse's/qualified same-sex domestic partner's coverage continues indefinitely, as long as premiums are paid. Other dependents may continue coverage until they are no longer eligible under PEBB rules. See the "Dependents" section on page 3 for details.

Your dependent(s) must apply for surviving dependent coverage within 60 days from the day you die.

Continuing Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that most employers sponsoring group plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates should coverage end because of certain "qualifying events." If you have the right to continue group coverage, you must enroll within 60 days and you'll need to pay your own premiums. COBRA rates exceed other self-pay rates by 2 percent. See your plan's certificate of coverage for details.

4 What if my enrolled child becomes ineligible during the year?

Contact your personnel, payroll, or benefits office. This will be particularly important if you are paying a monthly premium for your dependent's coverage. In addition, your child may be eligible to continue coverage under COBRA. See your plan's cerificate of coverage for details.

5 What should I do if my spouse/ qualified same-sex domestic partner is also eligible for PEBB coverage as an employee?

Both of you should enroll in PEBB medical and dental plans as employees, and then determine who will cover any eligible family members.

Preexisting Conditions

There are no preexisting condition restrictions or waiting periods for any PEBB-sponsored medical or dental plan.

Selecting a Plan

6 What plans are available?

The HCA offers a total of seven medical plans and three dental plans. Not all the plans are available in every county. In most cases, you must live in the plan's service area to join the plan. For more information on the medical plans offered in your county, review the "Plans Available by County" section. To find out where the dental clinics are located that are available through PEBB dental plans, see page 24.

7 How do I select the best plan for me and my family?

Only you can decide which plan makes the most sense for you and your family. If you cover eligible family members, they must be covered under the same medical and dental plan you choose.

As you review the plans, here are some things to consider:

Geography
In most cases, you must live in the plan's service area to join the plan. See the "Plans Available by County" section to find medical plans available in your county, and "How the Dental Plans Work" to find dental plans available in your area.

Cost
You share in the cost of your coverage by paying a monthly premium. Keep in mind, higher cost doesn't necessarily mean higher quality of care or higher benefits; each plan has the same basic level of benefits.

Unique medical needs
If you or a family member need certain medical care, you may want to choose a plan that provides the optimum benefits and coverage for the needed treatment, medications, or equipment. **Please note:** Each plan has a different formulary, which is a list of approved prescription drugs the plan will cover.

Coinsurance vs. copays
Managed care plans described in this guide require you to pay a fixed portion (called a "copay" or "copayment") at the time you receive network care. Under the Uniform Medical Plan (UMP), the enrollee is responsible for a coinsurance (percentage of an allowed fee). A coinsurance is also applied to extended network managed-care benefits, in addition to the copay.

Deductible
The UMP requires an annual medical/surgical deductible and prescription drug deductible be paid before the plan begins reimbursing for covered services. (Preventive care and certain other benefits are exempt from the UMP deductibles.) The extended network managed-care plan also has an annual deductible when you receive care from an extended network provider.

Out-of-pocket maximum
This is the maximum amount you pay in one calendar year. Once you have paid this amount, most plans pay 100 percent of allowed charges for most covered services for the remainder of the calendar year. The out-of-pocket maximum varies. For a list of expenses that apply to the out-of-pocket maximum, see the definition of annual out-of-pocket maximum in the "Glossary."

Referral procedures
Some plans allow you to self-refer to any network provider; others require that you have a referral from your primary care provider. Self-referral to a participating provider for women's health care services is a requirement of all plans. Contact your plan for further information, including limitations and restrictions.

Your provider
If you have a long-term relationship with your doctor or health care provider, you may want to see if (s)he is a primary care provider in the plan's network before you join.

Paperwork
In general, the plans don't require you to file claims. However, you may need to if you select the extended network managed-care plan and see an extended network provider, or if you enroll in the UMP and see a non-network provider.

Coordination with your other benefits
See "Coordination of Benefits" on page 10 for more information.

8 How do the plans differ?

See the "Medical Benefits Comparison" chart.

Cost

9 How much do the plans cost?

See page 15.

Premiums Paid With Pretax Dollars

Section 125 is the Internal Revenue Service code section which allows your employer to deduct money from your paycheck before certain payroll taxes and your income tax is calculated. This rule allows for deductions including monthly premiums for your medical coverage and for the state's dependent care program.

10 Why should I pay my monthly health care premiums with pretax dollars?

While the difference is not very noticeable, **you take home more money**, because taxes are calculated after the premium is removed. By paying for your coverage this way, you reduce your taxable income, which **lowers your taxes** and saves you money. For instance, someone in the 15 percent tax bracket with a $10 payroll contribution for health care coverage would take home around $2.25 more per paycheck than that person would if he or she did not have a Section 125 deduction.

11 Do I need to sign up for a Section 125 deduction?

No. It happens automatically unless you sign the Section 125 waiver form, available from your agency's personnel, payroll, or benefits office, saying you do not want your medical premiums deducted from your paycheck before your taxes are tabulated.

12 Can I change my mind about participating in the plan?

On a limited basis. You can only change your Section 125 choice during open enrollment each year, unless there is a change in your family circumstances, such as marriage, establishment or termination of a qualified same-sex domestic partnership, divorce, addition of a new child, or removal from coverage of a child who has reached the maximum age limit under our contract.

We may also remove you from the Section 125 plan, with notice, if it is necessary to prevent excess tax deferral.

13 When would it benefit me *not* to have a Section 125 deduction?

Reduction of social security salary base: The Section 125 plan reduces your social security salary base (if your base is under the $61,200 maximum) so you are saving money now, by not fully paying social security taxes. If you are nearing retirement age and participate in the plan, your lifetime social security benefit would be calculated using the lower salary.

Unemployment compensation: This plan reduces the salary base on which unemployment compensation is calculated.

To waive your Section 125 option, contact your agency's personnel, payroll, or benefits office for the necessary form.

14 Where can I get more information about Section 125?

For advice on your individual situation, you should talk to a qualified financial planner or your local Social Security Office.

Providers

15 How do I know if my doctor or hospital belongs to a plan?

Call the plan or your provider directly. The plan phone numbers are listed on the inside front cover. **Be sure you let them know you are a PEBB state of Washington enrollee.**

Or you may go to the online Provider Directory at www.pebb.hca.wa.gov. You can search for PEBB providers by name, clinic or office location, provider type, and medical plan. You can also search for hospitals and pharmacies that contract with the medical plans you're interested in. Chances are that your provider or hospital participates in one or more of the PEBB plans.

16 May I change providers after I have joined a plan?

Yes, although rules vary from plan to plan. Contact your plan directly for details.

17 Do all members of my family have to use the same provider?

They may select the same provider, but it's not required. Each member of your family may select his or her own provider available through the plan.

Changing Your Coverage

18 When may I change plans?

See page 6.

19 May I waive my dependent's medical coverage midyear?

Yes. You may waive coverage for your dependents at any time during the year. However, if your dependent needs to enroll in PEBB coverage outside of open enrollment, he or she must provide proof of continuous, comprehensive health care coverage or wait until the next open enrollment to enroll.

20 How do I enroll a new spouse/ qualified same-sex domestic partner or child?

You must submit a revised enrollment form and/or a *Declaration of Marriage/Same-Sex Domestic Partnership* to your personnel, payroll, or benefits office within 31 days of the marriage or establishment of the qualified same-sex domestic partnership, or 60 days for a newborn or newly adopted child. Otherwise, you must wait until the next open enrollment period to enroll your dependents. See "Adding and Dropping Dependents" on page 5 for more information.

Coordination of Benefits

21 How does my PEBB coverage work with my other group medical or dental coverage?

If you are also covered through your spouse's or qualified same-sex domestic partner's employer-provided health coverage, call both the medical and/or dental plans directly to ask how they will coordinate benefits. This may provide some cost savings for your family.

PEBB/HCA Administration

22 Who determines what the benefits will be?

The Legislature takes the first step by setting the benefits funding level. The Public Employees Benefits Board (PEBB), created within the Health Care Authority (HCA), then establishes eligibility requirements and approves the benefits plans of all participating health care organizations. The PEBB meets regularly to review benefit and eligibility issues and conduct strategic planning. Refer to the "Contents" page in the front of this guide for a list of the Board members.

23 Who administers the day-to-day operations of these programs?

The Washington State Health Care Authority (HCA) is the state agency that purchases and administers benefits within the amount funded by the Legislature. The HCA contracts with health plans and manages its own self-insured plans, the Uniform Medical Plan and Uniform Dental Plan, to provide a choice of quality health care options and responsive customer service to its members.

24 Who do I call if I have a question about an appeal?

First call your medical or dental plan to ask any questions about the appeal process.

If you've already filed an appeal with your medical or dental plan, and you are not satisfied with your plan's decision, contact your plan about further appeal rights.

If you have questions not answered by your plan within the plan's appeal timelines, you may call the Health Care Authority for assistance at 360-923-2625.

Medical Plans

Plans Available by County

Washington

Adams
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Asotin
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Benton
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Chelan
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Clallam
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Clark
- Kaiser Foundation Health Plan of the Northwest
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Columbia
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Cowlitz
- Kaiser Foundation Health Plan of the Northwest
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Douglas
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Ferry
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Franklin
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Garfield
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Grant
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Grays Harbor
- Group Health Cooperative of Puget Sound (ZIP Codes 98541, 98557, 98559, and 98568)
- Group Health Options, Inc. (ZIP Codes 98541, 98557, 98559, and 98568)
- PacifiCare of Washington, Inc. (ZIP Codes 98541 and 98557)
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Island
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Jefferson
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

King
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Kitsap
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Kittitas
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Klickitat
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Lewis
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Kaiser Foundation Health Plan of the Northwest (ZIP Codes 98591, 98593, and 98596)
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Lincoln
- Group Health Cooperative of Puget Sound (ZIP Codes 99008, 99029, 99032, and 99122)
- Group Health Options, Inc. (ZIP Codes 99008, 99029, 99032, and 99122)
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Mason
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- PacifiCare of Washington, Inc. (ZIP Code 98584)
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Okanogan
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Pacific
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Pend Oreille
- Group Health Cooperative of Puget Sound (ZIP Code 99009)
- Group Health Options, Inc. (ZIP Code 99009)
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Pierce
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

San Juan
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Skagit
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Skamania
- Kaiser Foundation Health Plan of the Northwest (ZIP Codes 98639 and 98648)
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Snohomish
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation
- RegenceCare
- Uniform Medical Plan

Spokane
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Stevens
- Group Health Cooperative of Puget Sound (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Group Health Options, Inc. (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Thurston
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Wahkiakum
- Kaiser Foundation Health Plan of the Northwest (ZIP Codes 98612 and 98647)
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Walla Walla
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Whatcom
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Whitman
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Yakima
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Oregon

Benton
- Kaiser Foundation Health Plan of the Northwest (ZIP Codes 97330, 97331, 97333, 97339, 97353, and 97370)
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Clackamas
- Kaiser Foundation Health Plan of the Northwest (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97222, 97267, and 97268)
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation (ZIP Codes 97034-35 and 97045)
- Uniform Medical Plan

Columbia
- Kaiser Foundation Health Plan of the Northwest
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Hood River
- Kaiser Foundation Health Plan of the Northwest (ZIP Code 97014)
- Premera Blue Cross/Foundation (ZIP Code 97031)
- Uniform Medical Plan

Lane
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Linn
- Kaiser Foundation Health Plan of the Northwest (ZIP Codes 97321, 97322, 97335, 97355, 97358, 97360, 97374, and 97389)
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Marion
- Kaiser Foundation Health Plan of the Northwest (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-14, 97325, 97342, 97346, 97352, 97359, 97362, 97373, 97375, 97381, 97383-85, and 97392)
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Multnomah
- Kaiser Foundation Health Plan of the Northwest
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation (ZIP Codes 97030, 97080, 97201-21, 97227-28, 97230-33, 97236, 97238, 97240, 97242, 97251, 97253-56, 97258-59, 97266, 97271-72, 97280, 97282-83, 97286, 97290, 97292-94, 97296, and 97299)
- Uniform Medical Plan

Polk
- Kaiser Foundation Health Plan of the Northwest
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Umatilla
- Group Health Cooperative of Puget Sound (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Group Health Options, Inc. (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Premera Blue Cross/Foundation (ZIP Codes 97801, 97810, 97813, 97859, 97862, and 97886)
- Uniform Medical Plan

Washington
- Kaiser Foundation Health Plan of the Northwest
- PacifiCare of Washington, Inc.
- Premera Blue Cross/Foundation (ZIP Codes 97005-08, 97075-76, 97116, and 97123-24)
- Uniform Medical Plan

Yamhill
- Kaiser Foundation Health Plan of the Northwest
- PacifiCare of Washington, Inc.
- Uniform Medical Plan

Idaho

Benewah
- Premera Blue Cross/Foundation (ZIP Codes 83824, 83851, 83861, and 83870)
- Uniform Medical Plan

Bonner
- Premera Blue Cross/Foundation (ZIP Codes 83804, 83809, 83813, 83821-22, 83825, 83840-41, 83848, 83852, 83856, 83860, 83862, and 83864-65)
- Uniform Medical Plan

Kootenai
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Latah
- Group Health Cooperative of Puget Sound
- Group Health Options, Inc.
- Premera Blue Cross/Foundation
- Uniform Medical Plan

Nez Perce
- Premera Blue Cross/Foundation (ZIP Codes 83501, 83524, 83540-41, and 83551)
- Uniform Medical Plan

Shoshone
- Premera Blue Cross/Foundation (ZIP Codes 83839, 83850, and 83868)
- Uniform Medical Plan

How the Medical Plans Work

The medical plans may differ in terms of their cost, type of providers and facilities, referral practices, and guidelines. While the plans have a basic level of benefits, some plans offer additional benefits or lower copays at no additional cost.

Please note: Services provided by plan-designated *alternative care providers* will be covered if the service they provide is within the scope of their license, covered by the PEBB benefit plan, and approved by your health plan. Please check with your health plan for information about coverage for a specific service.

There are three types of medical plans–here's how they work.

1. *Standard managed-care plans*: In this type of plan, you must see providers in your plan's network and receive most of your services through, or be referred by, a primary care provider (PCP). Nonemergency services outside the service area, or services not rendered by or referred by your PCP, are not covered. (**Please note:** *Premera Blue Cross* does not require selection of a PCP, and allows members to self-refer to network providers, including specialists.) Most services require a $10 copayment at the time of service, and there is no annual deductible to satisfy.

Urgent or emergency care is covered even if you receive services outside of Washington.

2. *Extended network managed-care plan*: This plan has network and extended network benefits. If you self-refer to a provider in the extended network rather than being referred by your PCP, the plan will still pay benefits, but at a lower level than if you followed the standard managed-care network guidelines and referral process.

Some extended-network benefits require payment of an annual deductible and copayment and/or coinsurance before the plan pays benefits. Then reimbursement is usually between 60 and 70 percent of allowed charges. Some benefits are not covered under the extended network. Contact the plan for specific extended-network benefits.

Urgent or emergency care is covered even if you receive services outside of Washington.

Important notice!

If your doctor leaves the plan before the next open enrollment, you are not allowed to change plans. Please keep this in mind when choosing a medical plan.

3. *Preferred provider organization (PPO)*: The Uniform Medical Plan (UMP) is a freedom-of-choice plan that provides worldwide coverage for routine and emergency care. The UMP offers an extensive provider network; this means you can self-refer to any approved provider type. Using network providers will reduce your out-of-pocket expense. Most services are subject to an annual deductible. See your UMP certificate of coverage for details.

2003 Monthly Employee Premiums

PEBB Medical Plans	Employee	Employee & Spouse*	Employee & Child(ren)	Employee, Spouse*, & Child(ren)
Kaiser Foundation Health Plan of the Northwest	$ 12	$ 33	$ 21	$42
Group Health Cooperative of Puget Sound	30	69	52	91
Uniform Medical Plan	36	82	63	109
PacifiCare of Washington, Inc.	40	91	71	121
Group Health Options, Inc.	44	98	77	131
RegenceCare	54	118	94	158
Premera Blue Cross	67	144	117	194

**or qualified same-sex domestic partner*

Please note: School district and employer group employees (who work for a city, county, port, water district, hospital, etc.) need to contact their payroll or personnel office to find out their monthly premiums.

Medical Benefits Comparison

The following table briefly compares the network benefits for the Uniform Medical Plan (UMP) in Washington and Oregon, and in-network benefits for PEBB managed-care plans. Call the plans directly for more information on specific benefits or exclusions.

Benefits for:	Annual deductible	Annual out-of-pocket maximum	Office, clinic, & hospital visits	Ambulance (air)	Ambulance (ground)	Chemical dependency services (inpatient)	Chemical dependency services (outpatient)	Diabetic education	Diagnostic testing
Standard managed-care plans: *Group Health Cooperative of Puget Sound* *Kaiser Foundation Health Plan of the Northwest* *PacifiCare of Washington, Inc.* *Premera Blue Cross/ Foundation* *RegenceCare* **Extended network managed-care plan (only in-network benefits described):** *Group Health Options, Inc.* **Please note:** Some extended network benefits are subject to an annual deductible. Please contact the extended network plan for details.	None	$750 per person/ $1,500 per family for network benefits	$10 copay per office/ clinic visit; hospital visits covered in full	$100 copay per trip Exception: *Kaiser Permanente*, $75 copay per trip	$75 copay per trip	Subject to inpatient hospital services copay; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment	Subject to office visit copay; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment	$10 copay per visit	100%
Preferred provider organization: *Uniform Medical Plan* **Please note:** The UMP pays 80% of allowed charges for most covered services by network providers outside of Washington and Oregon, and where network providers are not available. The UMP pays 60% of allowed charges for nonnetwork providers when a network provider is available. Contact UMP for details.	Medical/ surgical services: $200 per person/ $600 per family (three or more people) Prescription drug (retail and mail-order): $100 per person/ $300 per family (three or more people)	Medical/ surgical services: $1,125 per person/ $2,250 per family (does not apply to prescription drugs, non-network provider services, and other expenses as defined in the certificate of coverage)	90% reimbursement	80% of allowed charges reimbursement	80% of allowed charges reimbursement	Subject to inpatient hospital services copay; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment	90% reimbursement; maximum plan payment of $11,285 in any 24-month period for any combination of inpatient/ outpatient treatment	90% reimbursement	90% reimbursement

Durable medical equipment, supplies, and prostheses	Emergency room services	Hearing (examination & hardware)	Home health care	Hospice care (including respite care)	Inpatient hospital services	Mental health care (inpatient)	Mental health care (outpatient)	Neurodevelopmental therapies (inpatient) age 6 and under	Neurodevelopmental therapies (outpatient) age 6 and under
80% of allowed charges	$75 copay per visit; emergency room copay waived if admitted to hospital inpatient status	Examination: Subject to office visit copay Hardware: $300 maximum plan payment every 36 consecutive months for hearing aid and rental/ repair when authorized	100%	100% for terminally ill enrollees	$200 copay per day to $600 maximum copay per person per calendar year	$200 copay per day to $600 maximum copay per person per calendar year; plan payment limit up to 10 days per year (For more information, contact the plans.)	$10 copay per office/ clinic visit, up to 20 visits per year	Subject to inpatient hospital services copay to 60 days per year	Subject to office visit copay to 60 visits per year for all therapies combined
90% reimbursement; preauthorization required for equipment rentals beyond three months or purchases more than $1,000	$75 copay per visit, then reimbursed at 90%; copay waived if admitted to hospital inpatient status	90% reimbursement up to $400 every 36 months for exams, hearing aid, and rental/ repair combined	90% reimbursement	If preapproved by plan, 100% reimbursement; $5,000 lifetime maximum for respite care	$200 copay per day to $600 maximum copay per person per year	$200 copay per day to $600 maximum copay per person per calendar year; plan payment limit up to 10 days per year	90% reimbursement per office/ clinic visit, up to 20 visits per year	Subject to inpatient hospital services copay to 60 days per year	90% reimbursement to 60 visits per year for all therapies combined

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Benefits for:	Obstetric and well-newborn care (inpatient)	Obstetric and well-newborn care (professional services)	Organ transplants	Outpatient surgery, ambulatory surgery centers	Physical, occupational, speech, & massage therapy (inpatient)	Physical, occupational, speech, & massage therapy (outpatient)
Standard managed-care plans: *Group Health Cooperative of Puget Sound* *Kaiser Foundation Health Plan of the Northwest* *PacifiCare of Washington, Inc.* *Premera Blue Cross/ Foundation* *RegenceCare* **Extended network managed-care plan (only in-network benefits described):** *Group Health Options, Inc.* **Please note:** Some extended network benefits are subject to an annual deductible. Please contact the extended network plan for details.	Subject to inpatient hospital services copay for mother only	100%	Facility: Subject to inpatient hospital services copay Professional services: 100% Bone marrow donor searches covered in full up to 15 searches per person per transplant	$100 copay for facility fees per surgery or procedure (includes short-stay obstetrical services); surgeon, anesthesiologist, etc., paid in full	Subject to inpatient hospital services copay to 60 days per year	Subject to office visit copay to 60 visits per year for all therapies combined
Preferred provider organization: *Uniform Medical Plan* **Please note:** The UMP pays 80% of allowed charges for most covered services by network providers outside of Washington and Oregon, and where network providers are not available. The UMP pays 60% of allowed charges for nonnetwork providers when a network provider is available. Contact UMP for details.	Subject to inpatient hospital services copay for mother only	90% reimbursement	Hospital inpatient: Subject to inpatient hospital services copay; preauthorization required Professional services: 90% reimburse-ment; pre-authorization required Bone marrow donor searches reimbursed at 90% up to 15 searches per person per transplant	90% reimbursement	Subject to inpatient hospital services copay to 60 days per calendar year; preauthorization required	90% reimbursement, up to a total of 60 visits per calendar year for all therapies combined (also includes massage therapy; massage therapists must be UMP network providers)

Prescription drugs, insulin, & disposable diabetic supplies	Preventive care	Radiation & chemotherapy services	Skilled nursing facility care	Spinal manipulations (self-referred)	Temporo-mandibular joint (TMJ) disorder	Vision (examination)	Vision (hardware)	Well-baby care
Retail (up to a month's supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name, $25 copay; non-formulary, $40 copay **Mail order** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name, $50 copay; non-formulary, $80 copay Exceptions: *Group Health Cooperative* and *Group Health Options* have only $10 and $30 copays for retail, and $20 and $40 copays for mail order. *Kaiser Permanente* has only $10 and $25 copays for retail, and $20 and $50 copays for mail order.	100% subject to plan schedule	100%	Subject to inpatient hospital services copay; limited to 150 days per year, except if in lieu of hospital-ization	50% up to $250 maximum per year Exception: *Premera Blue Cross* pays 100%, subject to $10 copay per visit	Inpatient and outpatient surgical treatment paid at 50% to $1,000 maximum plan payment per year; orthognathic surgery not covered	Subject to office visit copay; one exam every 24 consecutive months	$50 maximum plan payment once every 24 consecutive months	100% subject to plan schedule
Up to 90-day supply, UMP formulary (subject to prescription drug deductible) **Retail:** Tier 1 (generic, all insulin, and all disposable diabetic supplies), 80% reimbursement*; Tier 2 (formulary single-source brand), 70% reimbursement*; Tier 3 (non-formulary single-source brand and all multi-source brand), 50% reimbursement **Tier 1 and 2 drugs purchased through a network retail pharmacy have a maximum enrollee cost share of $50 (up to a 30-day supply), $100 (31- to 60-day supply), and $150 (61- to 90-day supply)* **Mail order:** Tier 1, $10 copay**; Tier 2, $40 copay**; Tier 3, $80 copay** ***or cost of drug, whichever is less*	100% subject to plan schedule (not subject to medical/ surgical deductible)	90% reimburse-ment	Subject to inpatient hospital services copay; limited to 150 days per calendar year, except if in lieu of hospital-ization	90% reimburse-ment to 10 visits per year	Surgical treatment covered same as any other condition; 90% reimburse-ment when preauthorized; orthognathic surgery not covered	90% reimburse-ment once every two calendar years (not subject to medical/ surgical deductible)	$100 maximum plan payment every two calendar years for frames, lenses, contacts, and fitting fees combined (not subject to medical/ surgical deductible)	100% subject to plan schedule (not subject to medical/ surgical deductible)

General Medical Exclusions

Managed Care Plans

The following services and supplies are excluded from all PEBB-sponsored managed care plans. Plan-specific exceptions are noted. For further explanation of any exclusion, refer to the plan's certificate of coverage.

1. Services not provided by a plan-designated provider or obtained in accordance with the plan's standard referral and authorization requirements, except for emergency care or as covered under coordination of benefits provisions. (Does not apply to Group Health Options, Inc.)
2. Services rendered outside the service area when the need for care could have been reasonably foreseen by the enrollee before leaving the service area, unless preauthorized by the plan. (Does not apply to Group Health Options, Inc.)
3. Experimental or investigational services, supplies, and drugs.
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing, or insurance and related reports.
5. Services or supplies for which no charge is made, or for which a charge would not have been made if the enrollee had no health care coverage or for which the enrollee is not liable; services provided by a family member.
6. Drugs and medicines not prescribed by a plan-designated provider, except for emergency treatment. (Does not apply to Group Health Options, Inc.)
7. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
8. Skilled nursing facility confinement or residential mental health treatment programs for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature.
9. Conditions caused by or arising from acts of war.
10. Dental care including orthognathic surgery, nonsurgical treatment of temporomandibular joint (TMJ) dysfunction and myofascial pain dysfunction (MPD), and dental implants.
11. Sexual reassignment surgery, services, and supplies.
12. Reversal of voluntary sterilization.
13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization.
14. Services and supplies provided solely for the comfort of the enrollee, except palliative care provided under the "Hospice Care" benefit.
15. Coverage for an organ donor, unless the recipient is an enrollee of the plan.
16. Medical services, drugs, supplies, or surgery (such as but not limited to gastroplasty, gastric stapling, or intestinal bypass) directly related to the treatment of obesity.
17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
18. Orthoptic therapy (eye training); vision services, except as specified for vision care. Surgery to improve the refractive character of the cornea including any direct complications.
19. Orthotics, except foot care appliances for prevention of complications associated with diabetes which are covered.
20. Routine foot care.
21. Services for which an enrollee has contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the enrollee received double recovery for such services.
22. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
23. Any medical services or supplies not specifically listed as covered.
24. Direct complications arising from excluded services.
25. Pharmaceutical treatment of impotence.
26. When Medicare coverage is primary, charges for services or supplies provided to enrollees through a "Private Contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
27. Replacement of lost or stolen medications.
28. Recreation therapy.

Uniform Medical Plan

The following is an **abbreviated** list of exclusions for the UMP. The UMP does not cover any of the following, nor can such charges be applied to any required plan deductible or out-of-pocket limit.

In addition to any exclusions and maximums/limits mentioned in the *2003 Certificate of Coverage*, the UMP does not cover:

1. Acupuncture, except as described under "Acupuncture" in "Covered Expenses."
2. Additional portion of a physical exam beyond what is covered by the preventive care benefit, such as that required for employment, travel, immigration, licensing, or insurance and related reports.
3. Alcohol/drug information or referral services or enrollment in Alcoholics Anonymous or similar programs such as services provided by schools or emergency service patrol.
4. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
5. Any services or supplies not specifically listed as covered.
6. Autologous blood and its derivatives, including extraction or storage except when used for a covered peripheral stem cell rescue procedure.
7. Circumcision, unless determined medically necessary for a medical condition.
8. Complications directly arising from services not covered.
9. Conditions caused by or arising from acts of war.
10. Convalescent or custodial care (intended primarily to assist in activities of daily living and not requiring continued services of skilled medical or allied health professionals).
11. Cosmetic services or supplies except for:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly.
    - Restoring function.
12. Court-ordered care, unless determined by UMP to be medically necessary and otherwise within the UMP's coverage criteria.
13. Dental care other than the specific covered dental services listed in the *2003 Certificate of Coverage*. For example, the following are not covered:
    - Any treatment of caries or gum disease (including, but not limited to, extractions or aveoplasties) or other dental-specific services, regardless of the cause.
    - Dental implants.
    - Malocclusion resulting from accidental injury.
    - Nonsurgical treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction.
    - Orthodontic treatment.
    - Orthognathic surgery.
    - Treatment of injuries caused by biting or chewing.
    - Nitrous oxide.
14. Drugs or medicines not prescribed by an approved provider type, or not requiring a prescription, except as listed in exclusion 40.
15. Educational programs, such as nutritional counseling for cholesterol control, or lifestyle modification programs, except as described under "Diabetes Education" and "Tobacco Cessation Program."
16. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
17. Equipment such as:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Corrective shoes (except for diabetes).
    - Convenience items/options.
    - Exercise equipment.
    - Sanitary supplies.
    - Special or extra-cost features.
18. Experimental or investigational services, supplies, or drugs.
19. Food supplements (other than for PKU), such as infant or adult dietary formulas.
20. Foot care routine procedures, treatment of corns and calluses, corrective shoes, treatment of fallen arches or symptomatic complaints of the feet, orthotics, or related prescriptions. (Foot care appliances for prevention or treatment of diabetes complications, however, are covered.)
21. Hearing care services or supplies such as:
    - A hearing aid that exceeds specifications prescribed for correction of hearing loss.
    - Charges incurred after plan coverage ends, unless the hearing aid was ordered before that date and is delivered within 45 days after UMP coverage ends.

- Purchase of batteries or other ancillary equipment, except those covered under terms of the initial hearing aid purchase.

22. Home health care such as:
    - 24-hour or full-time care in the home, unless preauthorized.
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned under "Covered Expenses."
    - Dietary assistance.
    - Homemaker, chore worker, or housekeeping services.
    - Maintenance or custodial care.
    - Medically unnecessary services.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Supportive environmental materials/improvements (handrails, ramps, etc.).
    - Visits exceeding two hours per day, or daily visits beyond 14 consecutive days that have not been preauthorized.
23. Hospice care such as:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care," or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, or household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.
    - Supportive environmental materials/improvements (handrails, ramps, etc.).
24. Hospital inpatient charges such as:
    - Admissions solely for diagnostic purposes that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and approved by the UMP.
25. Immunizations, except as described under "Preventive Care." Immunizations for the purpose of travel or employment are not covered.
26. Impotence treatment with medications or pharmaceuticals.
27. Infertility or sterility testing or treatment, such as artificial insemination or in vitro fertilization.
28. Learning disabilities treatment after diagnosis, including for dyslexia, except as described under "Neurodevelopmental Therapy."
29. Maintenance therapy (see definition of maintenance care).
30. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations."
31. Marital, family, sexual, or other counseling or training services, except services provided by a UMP network licensed marriage and family therapist for neuropsychiatric, mental, or personality disorders.
32. Massage therapy, unless services meet the criteria in "Physical, Occupational, Speech, and Massage Therapy" under "Covered Expenses." Services from massage therapists who are not UMP network providers are not covered.
33. Mental, neuropsychiatric, or personality disorder treatment, except as described under "Mental Health Treatment."
34. Missed appointments, or completing or copying forms or records, except copying records to perform retrospective utilization review.
35. Non-network and out-of-network provider charges in excess of the plan's allowed charges.
36. Obesity treatment, including any medical services, drugs, supplies, or surgery such as gastroplasty, gastric stapling, or intestinal bypass.
37. Organ donor coverage for anyone who is not a UMP enrollee, or for locating a donor (such as tissue typing of family members),

except as described under "Organ Transplants."

38. Organ transplants or related services in nondesignated facilities, or transportation or living expenses related to organ transplants. See "Plan-Designated Facilities."
39. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)."
40. Over-the-counter drugs, except the following products when prescribed by an approved provider type licensed to prescribe drugs: insulin, prenatal vitamins, and nicotine replacement therapy (while participating in the Free and Clear tobacco cessation program).
41. Recreation therapy.
42. Replacement of lost or stolen medications.
43. Residential mental health treatment programs or care in a residential treatment facility.
44. Reversal of voluntary sterilization (vasectomy or tubal ligation).
45. Services or supplies to the extent benefits are *available* under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (Benefits are considered *available* if you are a named insured, come within the definition of insured, or are a third-party beneficiary under the policy.) However, UMP payments will be advanced upon request if you agree to apply for benefits under the other insurance or contract and to reimburse the UMP when settlement is received.
46. Services delivered by types of providers not listed as approved, or by providers delivering services of a type or in a manner not within the scope of their licenses.
47. Services of a non-network or out-of-network Licensed Master of Social Work, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, or non-Ph.D. psychologist, except when employed by and delivering services within a community mental health agency and that agency bills for such services.
48. Services of an out-of-network or non-network massage therapist/practitioner.
49. Services or drugs related to tobacco use and smoking cessation, except as described under "Preventive Care" and "Tobacco Cessation" in "Covered Expenses."
50. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member.
    - That are solely for comfort (except as described in "Hospice Care" in "Covered Expenses").
    - For which you are not obligated to pay.
51. Services or supplies obtained through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program–when Medicare is the primary payer.
52. Services received outside of required case management when you are required to participate in and comply with a case management plan as a condition of continued benefit payment (see the *2003 Certificate of Coverage* for details and exceptions).
53. Sexual disorder, diagnosis, or treatment.
54. Sexual reassignment surgery, services, counseling, or supplies.
55. Skilled nursing facility services or confinement for:
    - Mental health conditions.
    - Mental retardation.
    - Primarily domiciliary, convalescent, or custodial care.
56. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy, photo-keratectomy, or LASIK surgery.
57. Vitamins (except prenatal vitamins during pregnancy, when prescribed by an approved provider type licensed to prescribe drugs), minerals, or nutritional supplements.
58. Weight loss drugs, services, or supplies.
57. Wilderness training programs for chemical dependency.

If you have questions about whether a certain service or supply is covered, call the UMP at 1-800-762-6004 or 425-670-3000 in the Seattle area. You can also find the *2003 UMP Certificate of Coverage* online at www.ump.hca.wa.gov.

Dental Plans

How the Dental Plans Work

You have three dental plans to choose from:

Preferred Provider Organization (PPO)

- The ***Uniform Dental Plan (UDP),*** administered by Washington Dental Service (WDS), allows you the freedom to choose any dentist, but provides a higher reimbursement if your dentist contracts with WDS. The UDP *offers services in every county of Washington State*. Outside of Washington, services are reimbursed at a higher level than for services provided by non-PPO dentists in Washington.

Managed Care Plans

- ***DeltaCare, administered by WDS,*** requires selection of one of their network dentists when you enroll. You must verify your dentist contracts with DeltaCare as WDS administers several types of dental plans, each with its own provider network. This is important, as you could be responsible for costs if you receive care from a provider who is not in the DeltaCare network. *Providers are located in* Arlington*, Auburn, Bellevue, Bremerton, Burien, Edmonds*, Everett, Federal Way, Kent, Lynnwood, Mill Creek, Mukilteo, Olympia, Puyallup, Redmond*, Renton, Seattle, Shelton, Spokane, Tacoma, Tukwila, Tumwater, Vancouver, Wenatchee, Yakima, and Portland (Oregon).

**Not accepting new patients*

- ***Regence BlueShield Columbia Dental Plan,*** with services provided by Columbia Dental Group (CDG), requires that you receive care from CDG dentists. Their *clinics are located in*: Bellevue, Bellingham, Everett, Federal Way, Kent, Kirkland, Lynnwood, Northgate, Olympia, Puyallup, Richland, Seattle, Silverdale, Spokane, Tacoma, Tri-Cities (Kennewick), Tumwater, Vancouver, and Yakima.

Please note: Since clinic participation with the dental plans can change, please contact the dental plans to verify clinic locations.

Is a Managed-Care Dental Plan Right for You?

The table on the following page briefly compares the features of the UDP and the managed-care dental plans. Before enrolling in a managed-care dental plan, it is important to answer the following questions:

- Is the dentist I have chosen accepting new patients? (Remember to identify yourself as a PEBB state of Washington employee.)
- Am I willing to travel for services if I select a dentist in another service area?
- Do I understand that all dental care is managed through my primary care dentist or network provider, and I cannot self-refer for specialty care?

If your answer to these questions is yes, you may want to consider enrolling in a managed-care dental plan.

For full coverage provisions, including a description of limitations and exclusions, refer to a PEBB certificate of coverage (available through the dental plans).

Please note: Benefits for emergency care received out of the plan's service area; missed appointment charges; and the number of exams, x-rays, cleanings, and other procedures allowed in a certain time period *vary from plan to plan*. Contact the plans directly for details. (Dental plan phone numbers are listed on the inside front cover of this guide.)

If you are receiving continuous dental treatment (such as orthodontia) and are considering changing plans, contact the plans directly to find out how they cover your continuous dental treatment if you enroll in their plan.

More information on Washington Dental Service

Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers several dental plans, including the Uniform Dental Plan (UDP) and DeltaCare. If you choose UDP or DeltaCare, be sure that you choose a WDS-contracting dentist who participates with your plan.

Dental Benefits Comparison

(For more details on benefits and exclusions, contact the plans.)

	Preferred provider organization: ◆ ***Uniform Dental Plan***	**Managed-care dental plans:** ◆ ***DeltaCare*** ◆ ***Regence BlueShield Columbia Dental Plan***
Annual deductible	$50 per person/$150 per family, except for diagnostic and preventive	No deductible
Annual maximum	$1,500 plan reimbursement per person; except as otherwise specified for orthodontia, nonsurgical TMJ, and orthognathic surgery	No general maximum
Dentures	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	$140 copay, complete upper; $40 copay, complete reline (chairside)
Endodontics (root canals)	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$50 copay, 1 canal; $125 copay, 4 canals
Nonsurgical TMJ	70%; $500 lifetime maximum (dental plan payment)	70%; $500 lifetime maximum (dental plan payment)
Oral surgery	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$0 copay, single extraction; $10 copay, each additional tooth **Exception:** *Regence*, $0 copay, each additional tooth
Orthodontia	50%; $750 lifetime maximum (dental plan payment)	$1,500 maximum copay per case **Exception:** *Regence*, $1,200 maximum copay per case
Orthognathic surgery	70%; $5,000 lifetime maximum (dental plan payment)	70%; $5,000 lifetime maximum (dental plan payment)
Periodontic services	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$75 copay, gingivectomy or gingivoplasty per quadrant; $100 copay, osseous surgery per quadrant
Preventive/ diagnostic	100%, PPO; 90%, out of state; 80%, non-PPO (dental plan payment)	100% (dental plan payment)
Restorative crowns	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	$100 copay, resin base-metal crown **Exceptions:** *DeltaCare*, $175 copay, full or ¾ cast metal crown; *Regence*, $140 copay, full or ¾ cast metal crown
Restorative fillings	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	$10 copay, amalgam restorations (fillings), permanent teeth, two surfaces **Exception:** *Regence*, $0 copay

UDP and Regence Dental General Exclusions

The following services are not covered:

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.

2. Restorations or appliances necessary to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition (Uniform Dental Plan [UDP] only), and restorations for abrasion, erosion, or malalignment of teeth.

3. Application of desensitizing medicaments.

4. Services or supplies that the plan determines are experimental or investigative. Determination is made according to the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.

   a. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.

   b. The provider has not demonstrated proficiency in the service, based on experience, outcome, or volume of cases.

   c. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.

   d. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee's health or safety.

      Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols, or scientific data from another provider studying the same service.

   The documentation used to establish the plan's criteria will be made available for your examination at the office of the plan if you send a written request.

   If the plan determines that a service is experimental or investigative, and therefore not covered, you may appeal the decision. The plan will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.

5. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.

6. General anesthesia, including intravenous and inhalation sedation, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled (except for UDP only when in conjunction with covered oral surgery, endodontic, and periodontal surgical procedures).

7. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:

   a. A hospital setting for the dental care must be medically necessary.

   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.

   c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will

be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.

8. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.

9. Services for accidental injury to natural teeth when evaluation of treatment and development of treatment plan is performed more than 30 days from the date of the accident.

10. Expenses incurred after termination of coverage, except expenses for:
    a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
    b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
    c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.

11. Missed appointments.

12. Completing insurance forms or reports, or for providing records.

13. Habit-breaking appliances, except as specified under the orthodontia benefit.

14. Full-mouth reconstruction (Regence Dental also excludes dental implants).

15. Charges for dental services performed by anyone who is not a licensed denturist (Regence Dental only), dentist, or physician, as specified.

16. Services or supplies that are not listed as covered.

17. Treatment of congenital deformity or malformations.

18. Orthodontic treatment, orthognathic treatment, and treatment of temporomandibular joint (TMJ) disorders that are not authorized in advance by the plan.

19. Replacement of lost or broken dentures or other appliances.

20. Services for which an enrollee has contractual rights to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowner's, or other no-fault insurance.

21. In the event a UDP enrollee fails to obtain a required examination from a UDP (Washington Dental Service)-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment. (UDP only)

22. UDP (Washington Dental Service) shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract (UDP only).

DeltaCare General Exclusions

1. General anesthesia, including intravenous and inhalation sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.

2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.

3. Services for injuries or conditions which are compensable under Workers' Compensation or Employers' Liability laws, and services which are provided to the eligible person by any federal, state, or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.

4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion, or erosion without sensitivity and restorations for malalignment of teeth.

5. Application of desensitizing agents.

6. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/ observation. In determining whether services are experimental, DeltaCare (WDS), in conjunction with the American Dental Association, shall consider if: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause shall be notified of the denial within 20 working days of receipt of a fully documented request. Any denial of benefits by DeltaCare (WDS) on the grounds that a given procedure is deemed experimental, may be appealed to DeltaCare (WDS).

7. Dental services performed in a hospital and related hospital fees.

8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures).

9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage.

10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility, except for orthodontic services.

11. Cysts and malignancies.

12. Laboratory examination of tissue specimen.

13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.

14. Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

15. Prophylactic removal of impactions (asymptomatic, nonpathological).

16. Specialist consultations for non-covered benefits.

17. Implant placement or removal; however, crowns placed on implants will be covered.

18. Orthodontic treatment which involves therapy for myofunctional problems, TMJ dysfunctions, micrognathia, macroglossia, cleft palate, or hormonal imbalances causing growth and developmental abnormalities.

19. All other services not specifically included on the patient's copayment schedule as a covered dental benefit.

20. Treatment of fractures and dislocations to the jaw.

21. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law).

22. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare (WDS) or as cited under "Out of Area Emergency Treatment" in DeltaCare's certificate of coverage.

Glossary

Allowed charges
The maximum amount that your insurance plan will pay for covered services, treatments, or supplies.

Annual deductible
The amount you must pay each calendar year before the plan pays benefits for covered expenses. Most plans described in this guide do not have an annual deductible, except for the UMP and Group Health Options' extended network benefits. Some benefits may not apply to the annual deductible. Refer to your plan's certificate of coverage for details.

Annual out-of-pocket maximum
The most you would pay toward the majority of covered expenses in a calendar year. This means once you've reached your out-of-pocket maximum, most plans pay 100 percent of most covered expenses for the rest of the calendar year. These expenses apply to the out-of-pocket maximum:

- Inpatient hospital admissions
- Ambulance service
- Outpatient/day surgery and ambulatory surgery centers
- Physical, occupational, speech, and massage therapy
- Organ transplants
- Skilled nursing facility services

Group Health Options' extended network benefits and UMP benefits usually have different out-of-pocket limits from standard managed-care benefits. Refer to your plan's certificate of coverage for details.

Certificate of coverage
A legal document that describes eligibility, covered services, limitations and exclusions, utilization procedures, and other plan provisions. The medical or dental plan will provide you with a certificate of coverage once you are enrolled.

Coinsurance
The percentage you pay on claims for which your plan pays benefits at less than 100 percent.

Copays
The fixed cost you pay for services at the time you receive care. Most plans described in this guide require copays (sometimes called "copayments") when you see network providers or receive prescription drugs.

Drug formulary
A list of approved prescription drugs that the plan will cover. Each plan has a different formulary. Contact the plans for details.

Emergency
Conditions with symptoms so severe that most people would reasonably expect that, without immediate health care attention, the condition would:

- Seriously jeopardize the individual's physical or mental health.
- Seriously impair bodily functions.
- Cause a serious dysfunction of any body organ or part.

Your plan reserves the right to determine whether the symptoms indicate a medical emergency. See the plan's certificate of coverage for details.

Extended network
Enrollees in Group Health Options may choose from the Group Health provider network, or an extended network of providers. Extended network providers are outside of the Group Health network, but agree to provide services to Group Health Options' enrollees at negotiated rates. Enrollees are allowed to self-refer to extended network providers for covered services, but may have to pay an annual deductible and will receive a lower reimbursement from the plan.

HCA
The Health Care Authority (HCA) is a state agency that develops and administers health insurance programs for state and higher-education employees, retirees, and their dependents, as well as other eligible groups who choose to purchase PEBB coverage. The HCA provides medical, dental, life, and long-term disability insurance coverage to eligible enrollees through the Public Employees Benefits Board (PEBB). PEBB enrollees receive their benefits through private health plans that contract with the Health Care Authority and the self-insured Uniform Medical Plan and Uniform Dental Plan. The PEBB is responsible for designing and approving benefits plans and eligibility provisions for public employees, retirees, and their dependents, in accordance with state and federal laws.

Hospice care
Medical, therapeutic, nursing, or counseling services for a terminally ill patient and family enrollees by a public or private agency or organization for that specific service.

Inpatient
A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maximum plan payment for medical plans
The total amount paid out by each PEBB-sponsored medical plan, on behalf of each covered individual for all benefits, is limited to a lifetime maximum plan payment of $1,000,000. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by the plan during the prior calendar year. Some services are also subject to specific calendar year or lifetime benefit limitations, as detailed in each plan's certificate of coverage.

Midyear
Any time other than the open enrollment period.

Network
A group of health care providers in a certain geographic location (including doctors, hospitals, and other health care professionals and facilities) who agree to provide services to a health plan's members at negotiated rates.

Open enrollment period
The period of time each year during which you may change medical and/or dental plans, and add family members to your coverage without providing proof of previous coverage.

Outpatient
A patient who has not been admitted but is receiving covered services inside or outside a health care facility under a provider's direction.

Premium
The amount PEBB enrollees pay monthly for the cost of their health insurance. Premiums vary in cost depending on the health plan and the number of family members covered.

Primary care provider (PCP)
The doctor or nurse you choose to see for regular office visits, and who may refer you to and coordinate your care with specialists.

Some PEBB managed-care plans require each enrollee to have a primary care provider, who may be in family practice, internal medicine, or pediatrics. For some plans, women may also choose obstetricians or gynecologists for their PCP. However, each covered family member may have a different PCP. If you do not choose a PCP, some plans will choose one for you based on where you live. You may change your PCP during the year. The list of providers may be updated periodically.

Provider
A health care practitioner or facility operating within the scope of a license.

Specialist
A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Subnetwork
A provider group (such as hospitals, physicians, specialists, and other providers) whose providers may restrict your choice of referred specialists to only those within that same provider group.

Appendix A:
Medical and Dental Coverage Form

Public Employees Benefits Board (PEBB)

2003 Medical and Dental Coverage

- **List all eligible family members and indicate their enrollment status on this form.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.

Are you making changes to an existing account? ❑ Yes ❑ No	**If yes, what type of changes:** *(Check all that apply.)* ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan ❑ Adding family member ❑ Re-enrollment ❑ Waiving coverage ❑ Termination

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address	Apt./unit number

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)

The medical plans marked with an asterisk* in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. **Contact your plan or go to the Provider Directory on our Web site for code.**	Physician name or clinic code

Medical Coverage	❑ Enroll	❑ Waive: date effective _____	*If waiving, see Section 6.* **Note:** You may not waive medical coverage for yourself and cover family members.
Dental Coverage	❑ Enroll	(Dental may not be waived)	

Section 2: Spouse/Same-Sex Domestic Partner

*List your eligible spouse or same-sex domestic partner and indicate their enrollment status, even if you do not want coverage for them (see Section 6); they **cannot** be enrolled in any other PEBB coverage.*

Relationship to Subscriber

If adding a spouse/partner, please attach a completed *Declaration of Marriage/Same-Sex Domestic Partnership* form.

❑ Spouse: date of marriage _____

❑ Same-sex domestic partner: date criteria met _____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	Physician name or clinic code (contact plan for code)

Medical Coverage	❑ Enroll	❑ Waive: date effective _____	*If waiving, see Section 6.*
Dental Coverage	❑ Enroll	❑ Waive: date effective _____	

Terminate Medical & Dental Coverage

❑ Divorce/Dissolution of partnership: date of event _____

Please provide his/her new address _____

_____

❑ Death: date of event _____

Visit our Web site at www.pebb.hca.wa.gov

Washington State Health Care Authority
Public Employees Benefits Board
HCA 50-400 (10/02)

Agency Name	Agency/Subagency	Ins. Effective Date	Hire Date

Section 3: Family Member Information (such as child, grandchild, etc.)

*List all eligible family members and indicate their enrollment status, even if you do not want coverage for them (see Section 6); family members **cannot** be enrolled in any other PEBB coverage. **Use additional forms for more members.***

A **Relationship to subscriber** | ❑ Disabled? ❑ Student? (Check only if age 20 or older.) | Sex ❑ M ❑ F

Social security number | Physician name or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____

Dental Coverage ❑ Enroll ❑ Waive: date effective _____

If waiving, see Section 6.

❑ Terminate due to loss of eligibility

Reason _____

Date effective _____

B **Relationship to subscriber** | ❑ Disabled? ❑ Student? (Check only if age 20 or older.) | Sex ❑ M ❑ F

Social security number | Physician name or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____

Dental Coverage ❑ Enroll ❑ Waive: date effective _____

If waiving, see Section 6.

❑ Terminate due to loss of eligibility

Reason _____

Date effective _____

C **Relationship to subscriber** | ❑ Disabled? ❑ Student? (Check only if age 20 or older.) | Sex ❑ M ❑ F

Social security number | Physician name or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ❑ Enroll ❑ Waive: date effective _____

Dental Coverage ❑ Enroll ❑ Waive: date effective _____

If waiving, see Section 6.

❑ Terminate due to loss of eligibility

Reason _____

Date effective _____

Section 4: Medical Plan Selection *(Check only one.)*

❑ Group Health Cooperative of Puget Sound

❑ Group Health Options, Inc.

❑ Kaiser Foundation Health Plan of the Northwest

❑ PacifiCare of Washington, Inc.*

❑ Premera Blue Cross

❑ RegenceCare*

❑ Uniform Medical Plan

**These plans require the physician name or clinic code of your selected primary care provider. Contact the plan for code or go online to www.pebb.hca.wa.gov for provider directories.*

Section 5: Dental Plan Selection *(Check only one.)*

Preferred Provider Organization
(may receive services from any provider)

❑ Uniform Dental Plan (Group #3000)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Managed Care Plans

❑ DeltaCare (Group #3100) (must receive services from *DeltaCare provider*)
Dentist name or clinic code _____

❑ Regence BlueShield Columbia Dental Plan
(must receive services from *Columbia Dental Group provider*)
Clinic location _____

Section 6: Signature *(Required)*

I certify that my family members and I are eligible for the coverage requested. I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. I understand that I may be subject to dismissal and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be refunded if I am determined by the Washington State Health Care Authority to be ineligible for coverage.

I certify that I or any of my family members who have chosen to waive medical/dental coverage, as indicated above, currently have other continuous, comprehensive medical/dental insurance. I understand that proof of continuous, comprehensive medical/dental coverage will be required to re-enroll family members in a PEBB plan outside of an open enrollment period. Application for re-enrollment must be made within 31 days of losing other coverage.

Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Subscriber's signature _____ **Date** _____

Please sign and date this form. Return completed form to your Payroll or Insurance Office.

Appendix B: Adding a Spouse/Same-Sex Domestic Partner to Your PEBB Coverage

Adding a Spouse/Same-Sex Domestic Partner to Your PEBB Coverage

Washington State Health Care Authority
Public Employees Benefits Board

Important! Complete the form in this packet and return with a completed PEBB enrollment form.

Complete and return the form in this packet if you want to:

- Add a spouse to your Public Employees Benefits Board (PEBB) coverage, or
- Add a qualified same-sex domestic partner to your PEBB coverage.

Adding a Spouse

Remove the form from this packet.

Step One:

- Read through the declaration. You only need to fill out side A of the form.

Step Two:

- Print your names and the **date of your marriage** in the spaces at the top of the form.
- Sign, date, and provide your social security numbers at the bottom of the form.

Step Three:

- **Employees**: Return the form to your personnel, payroll, or benefits office.
- **All others**: Return the form to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Adding a Same-Sex Domestic Partner

Remove the form from this packet.

Step One:

- Review the declaration form; be sure you meet the 10 criteria for a same-sex domestic partnership.
- Print your names in the spaces at the top of the form.
- Sign, date, and provide your social security numbers at the bottom of the form.

Step Two (for **active employees** and **Medicare retirees** only):

- Review the *Declaration of Tax Status* form (side B).
- Determine whether your same-sex domestic partner fulfills the three requirements listed for Internal Revenue Code (IRC) Section 152 tax eligibility. **Your same-sex domestic partner does not need to qualify as an IRC Section 152 dependent to qualify for PEBB coverage.**
- Print your and your same-sex domestic partner's names at the top of the form.
- If you are unsure whether your same-sex domestic partner qualifies as an IRC Section 152 dependent, you may confirm eligibility by using the IRC *Worksheet for Determining Dependent Status* form. Go to Step Three.
- If your same-sex domestic partner qualifies as an IRC Section 152 dependent, go to Step Four.

Step Three:

- If completing the optional *Worksheet for Determining Dependent Status*, you and your same-sex domestic partner will need to know your:
  - Gross monthly income
  - Mortgage/rental payment
  - Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- Keep the worksheet for your personal tax records. You do not need to return the worksheet with the other forms.

Step Four:

- Sign, date, and print your social security number on the *Declaration of Tax Status* form.
- **Employees**: Return the forms to your personnel, payroll, or benefits office.
- **All others**: Return the forms to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Declaration of Marriage

Washington State Health Care Authority
Public Employees Benefits Board

A

I, _____, certify that
Print Subscriber's Name

_____ and I were legally married on _____/_____/_____
Print Spouse's Name month / day / year

- OR -

Declaration of Same-Sex Domestic Partnership

_____ and I established a same-sex domestic partnership beginning
Print Same-Sex Domestic Partner's Name

_____/_____/_____ and we meet the following criteria for a same-sex domestic partnership:
month / day / year

1. We have been same-sex domestic partners continuously for a minimum of six months.
2. We share the same regular and permanent residence.
3. We have a close personal relationship in lieu of a lawful marriage.
4. We have agreed to be jointly responsible for basic living expenses[1], as defined below, incurred during the domestic partnership.
5. We are not married to anyone.
6. We are each eighteen (18) years of age or older.
7. We are not related by blood as close as would bar marriage.
8. We were mentally competent to consent to a contract when the domestic partnership began.
9. We are each other's sole domestic partner and are responsible for each other's common welfare.
10. We are same-sex partners who are barred from a lawful marriage.

[1] "Basic living expenses" means the cost of basic food, shelter, and any other expenses of the common household. You and your same-sex domestic partner need not contribute equally or jointly to the payment of these expenses as long as it is agreed that both are responsible for them. If requested, you should be able to provide at least three of the following as verification of your joint responsibility (information should be dated to confirm eligibility at time of enrollment):

- Joint mortgage or lease.
- Designation of the same-sex domestic partner as primary beneficiary for a life insurance or a retirement contract.
- Designation of the same-sex domestic partner as primary beneficiary in the employee/covered member's will.
- Durable power of attorney for health care or financial management.
- Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
- A relationship or cohabitation contract which obligates each of the parties to provide support.

Subscribers are advised to consult an attorney regarding the possibility that the filing of this declaration may have other legal and/or financial consequences, including the fact that it may, in the event of the termination of the domestic partnership, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purposes of establishing and dividing community property, assigning community debt, and for the payment of support.

It is understood that:

- This declaration shall be terminated upon death of the spouse or same-sex domestic partner or by change of circumstance attested to in this declaration.
- Employees will notify their personnel, payroll, or benefits office and retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA)/self-pay members will notify the Health Care Authority at 1-800-200-1004 if the marriage has dissolved or the domestic partnership no longer meets all of the criteria attested to in this declaration within thirty-one (31) days of a change.

We declare, under penalty of perjury, that the foregoing information provided by us is true and correct and that all provisions of this statement have been met. Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____	- - _____	_____
Subscriber's Signature	Social Security Number	Date
_____	- - _____	_____
Spouse or Same-Sex Domestic Partner's Signature	Social Security Number	Date

Agency use only	Agency	Subagency

Declaration of Tax Status

B

I, _____, have completed a *Declaration of Marriage/Same-Sex Domestic Partnership*
Print Subscriber's Name

form and have sworn that _____ is my same-sex domestic partner. I understand
Print Same-Sex Domestic Partner's Name

that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that a same-sex domestic partner is considered an Internal Revenue Code (IRC) Section 152 dependent **only if each** of the following requirements is met (does **not** affect your same-sex domestic partner's eligibility for PEBB coverage):

1. The same-sex domestic partner and I live together (share our principal abode) for the full taxable year, except for temporary absences for reasons such as vacation, military service, or education. In other words, my same-sex domestic partner and I must live together from January 1 through December 31.
2. The same-sex domestic partner is a citizen or resident of the United States.
3. The same-sex domestic partner receives more than half of his or her support from me. The rules for determining support are complicated and are more involved than just determining who is the "primary breadwinner." Attached is a worksheet similar to one the Internal Revenue Service (IRS) includes in its Publication 17 that you can use to determine whether you provide more than half of your same-sex domestic partner's support.

Please Note:

Even if the above requirements are met, an individual cannot be considered an IRC Section 152 dependent if the relationship violates local law.

Check one of the following boxes; **coverage is only available** if you check a box. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances. I declare that:

- ❑ **Yes**, my same-sex domestic partner **is** my Internal Revenue Code Section 152 dependent.
- ❑ **No**, my same-sex domestic partner is **not** my Internal Revenue Code Section 152 dependent. As a result, premium contributions for my same-sex domestic partner cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.
- ❑ **Yes**, my same-sex domestic partner's child(ren) **is** my Internal Revenue Code Section 152 dependent(s).
- ❑ **No**, my same-sex domestic partner's child(ren) is **not** my Internal Revenue Code Section 152 dependent(s). As a result, premium contributions for my same-sex domestic partner's eligible family members cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.

By signing below, you are stating that:

I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand that this declaration of responsibility may have legal implications under federal and/or state law. I understand that a civil action may be brought against me for any losses, including reasonable attorney's fees, because of a false statement contained in this *Declaration of Tax Status*. I also certify under penalty of perjury, under the laws of the state of Washington, that the foregoing is true and correct.

I, the undersigned subscriber, understand that willful falsification of information on this declaration may lead to disciplinary action, up to and including discharge from employment and/or disenrollment from PEBB coverage. I agree to notify my personnel, payroll, or benefits office or the Health Care Authority at 1-800-200-1004 if there is any change in the circumstances attested to in this declaration within thirty-one (31) days of the change. *I am aware that any change in my family tax status may directly impact the calculation of my taxable income.*

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____	- - _____	_____
Subscriber's Signature	Social Security Number	Date

Worksheet for Determining Dependent Status

☞ Do **not** return this form; keep for your own tax records.

(Worksheet modeled after the IRC worksheet in Publication 17)

Important

You can use this worksheet to determine whether your same-sex domestic partner and/or his or her child(ren) qualify as dependents under Internal Revenue Code (IRC) Section 152 (in general, he or she must receive more than half of his or her support from you).

Income

1. Did the same-sex domestic partner you supported receive any income such as wages, interest dividends, pensions, rents, social security, or welfare?
   - ❑ Yes (Answer questions 2, 3, 4, and 5.)
   - ❑ No (Skip to question 6.)
2. Total annual income received $ _____
3. Amount of income used for your same-sex domestic partner's support $ _____
4. Amount of income used for purposes other than support $ _____
5. Amount of income either saved or not used for lines 3 or 4 $ _____

The total of lines 3, 4, and 5 should equal line 2.

Yearly household expenses where you and your same-sex domestic partner lived

6. Lodging (*Complete either a or b):*
   a. Rent paid $ _____
   b. If not rented, show fair rental value of your home $ _____
   If your same-sex domestic partner owned the home, include this amount on line 20.
7. Food $ _____
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) $ _____
9. Repairs that were not included in line 6a or 6b $ _____
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). $ _____
11. Add lines 6a or 6b through 10 $ _____
12. Total number of persons who lived in household _____

Yearly expenses for your same-sex domestic partner

13. Divide line 11 by line 12 to determine each person's part of household expenses

    $ _____ (line 11) ÷ _____ (line 12) = $ _____ (line 13)

14. Clothing $ _____
15. Education $ _____
16. Medical and dental $ _____
17. Travel and recreation $ _____
18. Other (please specify) _____ $ _____
    _____ $ _____
    _____ $ _____
19. Total amount for your same-sex domestic partner's yearly support (Add lines 13 through 18) $ _____

20. Amount your same-sex domestic partner provided for his or her own support

    Line 3 $ _____

    Line 6b (include if your same-sex domestic partner owned the home) $ _____

    Add lines 3 and 6b, if each are applicable $ _____ line 20

21. Amount that others added to your same-sex domestic partner's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts included on line 2. $ _____

22. Amount **you** provided for your same-sex domestic partner's support:

    $ _____ (line 20) + $ _____ (line 21) - $ _____ (line 19) = $ _____ (line 22)

23. 50% of line 19 $ _____

If line 22 is more than line 23, your same-sex domestic partner qualifies as an IRC Section 152 dependent. Check "Yes" on the *Declaration of Tax Status* form.

If line 22 is **not** more than line 23, check "No" on the *Declaration of Tax Status* form. As a result, the amount that **the state will contribute** (shown below) for your qualified same-sex domestic partner and/or child(ren) is considered taxable by the IRS. The tables below show the amount that will be added to your total gross income and calculated into your withholding tax; this will be reflected on your pay stub, as well as your *Wage and Tax Statement* (your W-2). The monthly amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

Active employees

	2003 State Contribution for Medical and Dental Coverage for:		
Medical Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
Community Health Plan	$276	$223	$499
All other medical plans	$285	$230	$515

	2003 State Contribution for Dental Coverage (Without Medical Coverage) for:		
Dental Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
All dental plans	$33	$33	$66

Medicare retirees

Medical Plan	**2003 State Contribution for Medical Coverage for Partner**
Premera Blue Cross Medicare Supplement Plan E	$46
PacifiCare	$79
Kaiser Permanente	$84
All other medical plans	$93

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm data before making decisions.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.